“Fostering a Positive Safety Culture”

Wessex Quality and Improvement Conference
15 June 2016

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Lead Practice Educator
Chair of the Positive Safety and Culture team
University Hospital of Southampton Foundation Trust
Marie is a newly qualified midwife, who is new to the unit.

Marie became concerned re CTG. Rather than escalate her concerns regarding a ? pathological trace to senior midwife (who Marie perceived was not easy to talk to & not visible) she spoke only to the very friendly & junior registrar.

Despite Marie’s concerns the junior registrar misinterpreted the trace on 3 occasions. Furthermore he did not explain to the midwife why he was not concerned.

Neither the registrar or Marie sought support from the senior registrar or the senior midwife.

The registrar wanted to show he could cope as his colleagues were tied up in theatre.
Deaths of 11 babies and 1 mother found to be completely preventable

Over 50% of intrapartum fetal deaths were likely to have received suboptimal care

70% of direct deaths and 55% of indirect deaths of mothers due to substandard care
Contribution of HF issues to Obstetric SUIs

WORM’ analysis applied:

- a. Workmanship 44.2% [knowledge, skills]
- b. Omissions 61.6% [SA, decision-making]
- c. Relationships 47.7% [communication, team-working]
- d. Mentorship 31.2% [leadership, multidisciplinary]

83% of cases exhibited Human Factor issues
79% of these involved ‘multiple’ HF issues
Best Practice
Reducing Avoidable Harm to Mothers & Babies

• Build technical and non-technical skills
• Responding to reports and guidelines
• Evidence-based, multi-disciplinary teaching
The Report of the Morecambe Bay Investigation

A promise to learn – a commitment to act

improving the safety of patients in england

national advisory group on the safety of patients in england

Better Births

Improving outcomes of maternity services in england

Five Year Forward View for Maternity Care

The Code

Professional standards of practice and behaviour for nurses and midwives
Safety Cultures in trouble!

- Approachability
- Listener’s capacity, workload
- Not knowing people, jargon
- Voice, accent, tone, volume
- Noise
- Stress
- Personal style
- Interruption
- Culture, status, loss of face
- Authority gradient
Exploring culture

Culture like yeast, permeates all parts of an organisation, just as yeast is needed into all parts of the dough.

Although invisible, yeast like culture of an organisation exerts influence from within ...... The outcome is the behaviour (or bread)!
Definition

A Safety Culture "the product of the individual and group values attitudes and perceptions and patterns of behaviour that determine a team or organisation’s commitment to safety management"

INSAG 1991 (International Nuclear Safety Advisory Group)

“The way we do things around here”

Verweij, Hofstee, Golding et al 2009
Transforming the safety culture in aviation!

Tenerife - 1997
- The world’s worst aviation disaster
- Two Boeing 747s
- KLM 4085 and PAN AM 1736
583 mortally wounded or died

Hudson River, 2009
ALL 155 SURVIVED – WHY?
The safety Climate—the measurable components of safety culture. A snapshot of culture at a given moment.
“An Investigation into the Attitude of Health Professionals into Team Working on the Delivery Suite”

**Methods:** Descriptive study, cross sectional design. The Human Factors Attitude Questionnaire was administered to 4 professional groups. Full ethical approval.

**Results:** A 63% response rate

- Some senior leaders inhibited upward communication.
- Inappropriate behaviour was reported.
- Just 55.3% (83) of midwives, felt it was easy to ask questions.
- 25.2% (38) of midwives reported difficulties speaking up.
- Just 44.7% of midwives felt positive about their involvement in decision making.
- The majority of all health professionals felt debriefing skills need to be improved.
The Positive Safety & Culture Team

- Enthusiastic multi-professional group
- Meets monthly.
- Forum to discuss issues pertaining to culture & safety
- To implement recommendations from the study.
- Embrace the 6 attributes associated with a positive safety culture.
Within positive safety cultures, teams are associated with 6 attributes

1. Appropriate authority gradients exist where hierarchies do not stifle the free flow of information.

2. Superiors are approachable and always listen to concerns and respond appropriately.

3. Participation is open and supportive involving all parties.

4. In effective teams Inappropriate behaviour is not accepted!

5. “Tribalism & Group think is condemned”!

6. Regular feedback and debriefing & further action to close the loop.
Developing ourselves as individuals and as a ‘high-performing team’

We’ll be exploring you as individuals and your teamwork in some detail, using your experiences and examples, with a focus on how to be even more effective day-to-day, every day.

Please be thinking about your own examples of effective teamwork as well as those times when, perhaps, you/the team has struggled …

We look forward to seeing you on Friday 7th.

David Young  Caroline Nesbitt
Leadership Development

Southampton University Hospitals NHS Trust
"We’re only Human 1 & 2"

Human Factors & Safety in Maternity Services

An interactive and multidisciplinary conference

Tuesday 4th March 2014
Chilworth Manor
Southampton

Friday 6th March 2015
S.G.H
Southampton
1. Appropriate authority gradients exist where hierarchies do not stifle the free flow of information.

➢ Status, level of education, professional roles, gender, ethnicity & perceived expertise hinders communication

➢ making it difficult to challenge!

➢ Also difficult to listen and heed warnings!

➢ You’re too low’

➢ ‘No I’m not...........I’m the Captain.........’
2. Superiors are approachable and always listen to concerns and respond appropriately.

- Do you shoot the messenger?
- Do people feel unable to speak to you?
- Can people easily raise an issue or ask a question?
Core values: agreed by clinical leaders in Birth Environments within PAH. The purpose is to encourage a positive team working culture.

✓ We are visible & accessible
✓ We are approachable
✓ We listen
✓ All questions about practice & care are appropriate
✓ We model best practice
✓ We give & receive positive & constructive feedback
✓ We build confidence
✓ We promote trust
✓ We practice & promote effective team working
✓ We support our staff
Team leader Qualities

➢ Consistent approach
➢ Fairness
➢ Invests time
➢ Listen’s & reflects back
➢ Toughness
➢ Reliable & Trustworthy
➢ Courtesy/manners values
➢ Selfless/humility
➢ Credible
3. Participation is open and supportive involving all parties.

*Remember the most junior member of staff may hold significant information that may drastically impact on her care!*

I might as well not be here!

Is anyone else going to be heard?
Emergency Response (5xS)

- **Sign** poster
- **Select** Team Leader
- **Supplies**
- **Scribe**
- **Support**
Handover in progress

Enter only in an emergency

Interruptions put patients at risk
Effective Handover

- Start on time
- Include all incoming and as many outgoing team members as possible
- Give keys to staff not involved in handover
- Shut the door
- Start with team introduction
- Co-ordinator / SR will lead and invite contributions and questions
- Consider the bigger picture: SHARING
- Discuss each patient using SBAAR
- Remember to respect each other and patients

"Handover of care is one of the most perilous procedures in medicine and when carried out improperly can be a major contributory factor to subsequent error and harm to patients."

Prof John Lilleyman, NPCC 2003

Staffing levels
High risk antenatal patients
Admissions to SGH
Room on Burley
Inductions
Neonatal cots
Gynae patients
Involve the parents at handover

*Nothing about me without me!*

Equity & excellence : Liberating the NHS (2010)

- Unique (whole pathway).
- Acutely aware of shortages / communication issues
- But also mostly uncomfortable & unwilling to challenge.

“There appeared not to be a handover... I could have told them about the traces”
**Risk Assess: Handover Proforma**

- Please ensure it is completed and placed in the patient’s notes (within the narrative) when handing over care in labour as well as on transfer of all patients from any environment.
- In all cases **face-to-face handover** is considered best practice.
- Please complete a full Risk Assessment. This should include reviewing the notes & accessing EDOCS.
- The name of individuals involved in the transfer and subsequent receipt of patient must be documented.

### SBAR MATERNITY HANOVER OF CARE

<table>
<thead>
<tr>
<th>Situation</th>
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<tbody>
<tr>
<td>Date of Handover:</td>
<td>Time of Handover:</td>
</tr>
<tr>
<td>From Ward/Area:</td>
<td>Midwife/Nurse</td>
</tr>
<tr>
<td>To Ward/Area:</td>
<td>Midwife/Nurse</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Background</th>
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</thead>
<tbody>
<tr>
<td>Please circle: Antenatal / Labour / Postnatal / Baby</td>
<td></td>
</tr>
<tr>
<td>Party:</td>
<td>Gestation:</td>
</tr>
<tr>
<td>Risk factors and significant events:</td>
<td></td>
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</tbody>
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**Assessment and Recommendations**

Please document any concerns regarding MMEWS, medication, outstanding results/investigations etc and outline care plan

Mother: | Fetus/Baby: |  |

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Get to know your team

Rowena Williams
Education Administrator
Women & Newborn

Sally Burton
Midwife Practitioner-Education/S.O.M.
Obstetrics & Gynaecology

Robyn Madeleine Damary-Homan
(Maddie)

Hello, I am Maddie. I trained here in Southampton and I moved here to study, so I guess you could now say, I’m from here! I have a horse and four house bunnies. I like playing badminton with a bunch of rather competitive engineers and I like to go crabbing (as seen in the picture!). And that’s me!

University Hospital Southampton
NHS
Assertive language

Critical language agreed upon phrases to halt perceived unsafe activity e.g.:

- “Are you sure you want to put the ventouse cap on again?”
- “Is additional senior/consultant/ anaesthetic support required?”

The two challenge rule when individuals are required to speak up at least twice when threats are identified regardless of status e.g.:

- “I am now telling you for the second time the C.T.G. in room 5 looks abnormal & needs urgent attention”.

CUSS

- (CONCERNED……, UNCOMFORTABLE….., SAFETY ….., STOP……..a patient issue)
4. In effective teams Inappropriate behaviour is not accepted!

➢ Remember rudeness or/incivility impairs the recipients or any witnesses cognitive skills negatively which affects care.

➢ Reluctant witnesses.
➢ Collusion to avoid attention
➢ “Love-bombing”

High acuity may lead to shouting & undirected questions (Berridge 2010). Novices in theatre respond with behaviour which heightens rather than resolves personal conflict (Linguard et al 2002)!
The undermining toolkit is an RCOG/Royal College of Midwives (RCM) initiative to address the challenge of undermining and bullying behaviour in maternity and gynaecology services. **Strategic interventions**

- **Unit trust and local education provider interventions**, 
- **Departmental and team interventions**
- **Individual Interventions**

5. Tribalism & Group think is condemned

• Behaviour and attitudes that stem from loyalty to a tribe or other in-group
• Negative stereotyping
• Failing to see the other persons perspective
• Gets in the way of patient care

“Tribalism has a profound impact on the profession – we are a dysfunctional profession at that level right through the system, and it is hurting us”.

Sir Donald Irvine (16 December 2004)
6. Regular feedback and debriefing & further action to close the loop.

1. Improves Patient safety.

1. Drives quality improvement / Identify communication and equipment deficiencies.

1. Enhances group cohesion, & team building.

1. Reduces staff stress, provides support and reduces alcohol misuse.

1. Encourages critical analysis of performance retrospectively.

1. Individuals learn better as active participants
Why Debrief:
Symptoms associated with acute, excessive sustained stress

1. Cognitive impairment
2. Emotional reactions.
3. Physical problems.

Neily et al., JAMA 2010; 304: 1693-1700

- Team training intervention; briefings, debriefings, 1 year of quarterly coaching
- Absolute reduction in mortality from 17/1000/year procedures at baseline to 14/1000/year after training
Hot debriefing is here!
Hot Debriefing Audit
10 proforma’s included

Who led the process:
- 23% labour ward co-ordinators
- 5 ??% Obstetric Consultant
- 23% by Registrar’s
- 15% Midwives

Type of Incident
- 64% post emergency
- 18% post live drill
- 2% post live drill

Timing
- 10 debriefs took place in 24 hours.
- 1 post 24 hours
Hot Debriefing Audit

Green Comments : what was good

- Good teamwork and good communication
- Risks anticipated by all
- Senior involvement in plan
- Rapid response to call.

Amber comments
- Protocol fell off eclampsia trolley
- Flow charts difficult to find : add tabs.
- Importance of watching the clock
- Bladder care issues - 750ml contributed to atony

Red comments
- Remember to put back of bed down.
- Buzzer not heard from room11 doctors did not come
- Remind theatre staff to use 2222 in an emergency
Positive culture team:
Improving patient safety on Labour ward
I. van Herwijnen, S. Burton, J. Mountfield

- Repeat dip into the climate in 2013
- Questionnaires were completed by midwives, obstetricians, anaesthetists and neonatologists within the maternity unit
- Notable (24.7%) improvements in the midwives ability to ask questions when they are unsure
- Marked improvement in decision making (44.7%) involving the whole MDT. This was corroborated by the GMC survey.
Plans underway for 2016

- Launch “Caring for all” September 15th 2015.
- Promoting regular informal positive & feedback amongst all team members.
- Establishing a leader /hot shot notice boards.
- Reviewing the structure of our current PMM meetings.
Our Positive Safety Culture - still evolving

Small innovations can lead to huge wins.
Going forward our intention is to:

✓ Sustain maximum resistance to operational hazards regardless of the leadership, personalities and skill mix.
✓ Ensure and sustain adequate training, good communication, clear procedures, and compliance with safe operating practices.
✓ Continue to appreciate and proactively deal with known defensive gaps as they arise.
✓ Above all we wish to continue to support and value our workforce.
Thank you